ADDENDUM FOR OLDER ADULTS

(Sample* Self -Administered Health Risk Profile)

Name:_____ **Today's Date:**_____
(Month, Day, Year)

Date of Birth:_____**Age:**_____ **Male:**___ **Female:**___ **ID#:**_____

Please put a check mark by each sentence that applies to you. If you do not know the answer to a question, put a mark by it and someone will discuss it with you. Your answers to these questions will help your doctors and nurses design a preventive health care plan that will show you what you can do to help yourself stay healthy and free of injuries.

Please DO NOT write in boxes marked "Risk?" or "Ed. ✓"

Annual Assessment of Risk Factors	**Risk?**	**Ed. ✓**
1. SOCIAL ENVIRONMENT		
____ I am the principal care giver for my disabled spouse or adult child with mental illness.	**Y N**	
____ I do not have family or friends available, able and willing to assist me when needed.		
____ I participate in few or no activities outside my home.		
____ Does not apply to me.		
2. SAFETY		
____ I do not have a secure grab bar and a rubber mat/decals in my bath or shower.	**Y N**	
____ I have fallen in the past year. How/Where?_____ Injury?_____		
____ I take medicine ordered by more than one doctor. What?_____		
____ I take non-prescription medicines. What? _____		
_____I need help to take my medicine correctly (the right time, dose, medicine, etc.).		
____ Does not apply to me.		
3. NUTRITION		
___ I have changed the kind or amount of food I eat.	**Y N**	
___ I don't always have enough money to buy the right kinds of food.		
___ I have missing teeth or ill-fitting or missing dentures.		
___ I have difficulty swallowing.		
___ I eat fewer than 2 meals each day.		
___ I eat alone most of the time.		
___ Does not apply to me.		
4. DEPRESSION		
___ I have been told by a doctor that I am/was depressed.	**Y N**	
Doctor's Name:_____		
___ My spouse, or a close family member or friend, passed away during the past year.		
___ I feel "blue" and tired a lot or I don't sleep well and have a poor appetite.		
___ I have thought about or have tried to take my own life. In the past? ____ Recently?____		
___ Does not apply to me.		

Annual Assessment of Risk Factors	Risk?	Ed. ✓

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5. COGNITIVE FUNCTION ___ I sometimes forget simple words or use words that don't make sense. ___ I sometimes get lost in or going to familiar places. ___ I have trouble making change or paying bills. ___ Someone in my family has/had Alzheimer's Disease. Who?_____ **___ Does not apply to me.**	**Y N**	
6. INSTRUMENTAL ACTIVITIES OF DAILY LIVING ___ I need help to manage my money and pay bills. ___ I need help (taxi, family, bus) to go places that are too far from my home to walk. ___ I need help with housework like sweeping, washing clothes or dishes. **___Does not apply to me.**	**Y N**	
7. SENSORY ___ Someone in my family has had glaucoma. Who?_____ ___ It has been more than 1 year since I had my eyes examined. ___ I do not hear as well as I should, and/or I have ringing in my ears. **___ Does not apply to me.**	**Y N**	
8. ELIMINATION ___ I have trouble controlling my bladder or bowels, or I have "accidents." ___ I have difficulty starting my urine stream (male). ___ I use laxatives every day or almost every day. **___ Does not apply to me.**	**Y N**	
9. INTIMACY ___ I have difficulty achieving or maintaining an erection (male). ___ I have vaginal dryness or irritation, and/or sex is painful for me (female). ___ Since I (or my partner) have been ill (heart attack, surgery, other major illness), I am afraid that it might hurt or cause another heart attack if we have sex. **___ Does not apply to me.**	**Y N**	

*Inclusion/omission does not imply that the Texas Department of Health endorses or rejects a specific recommendation or authority opinion.

Notes or questions:_____

Clinician review with client: _____Date:_____

Put Prevention Into Practice-PPIP

www.state.tx.us/ppip/index.htm

(512) 458-7534

Sample* Preventive Care Flow Sheet: Addendum for Older Adults

Name: _____ ID#: _____ Date:_____

Check if applicable:	**Initials/Date(s) of education/counseling**	**Check if applicable**:	**Initials/Date(s) of education/counseling**
‘ Social Environment	_____ _____ _____	‘ Elimination	_____ _____ _____
‘ Safety	_____ _____ _____	‘ Sexual Intimacy	_____ _____ _____
‘ Nutrition	_____ _____ _____	‘ _____	_____ _____ _____
‘ Depression	_____ _____ _____	‘ _____	_____ _____ _____ _____
‘ Cognitive Function	_____ _____ _____	‘ _____	_____ _____ _____ _____
‘ IADLs/ADLs	_____ _____ _____	‘ _____	_____ _____ _____ _____
‘ Sensory	_____ _____ _____	‘ _____	_____ _____ _____ _____

Suggested Result Codes: N=Results Normal A=Results Abnormal R=Refused P=Pending

Screening test/exam	**Freq.**		**Yr. Age**	**Yr. Age**	**Yr. Age**	**Yr. Age**	**Yr. Age**
Depression questionnaire		Date/ Result					
Mini Mental State Exam		Date/ Result					
Snellen acuity test		Date/ Result					
Otoscopic Exam		Date/ Result					
Audiometric Testing		Date/ Result					
		Date/ Result					

Referrals:	**Date**	**Result**
Audiological Evaluation		
Ophthalmology Evaluation		
Mental Health Evaluation		
Neurological Evaluation		

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Use with forms 10-50 and 10-50A

AHP - 01/01